

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30459

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			LOUISE			Nov. 7, 1983			3:30 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
female		white		July 8, 1910		73		YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Kent Co.		MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Worton		at Home RFD Worton, Md.		Housewife				21678			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Md.		Kent		Norton				RFD			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
		Grove	Cleveland	Elliott			Mattie	Ella	Ruark		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		213 42 0959		Emily B. Stubbs		Worton, Md. 21678					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))		4100		Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		immediate			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				(b) Arteriosclerosis Heart disease				5 years			
19. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/24/83 to 10/24/83, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did not) visit the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING <input checked="" type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		11/17/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		Wayne D. Benjamin		22e. ADDRESS		Chestertown, Md. 21620					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 11/9/83		23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery		23d. LOCATION CITY OR TOWN County State		Chestertown, Md.			
Burial											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
G. William Wells		Chestertown, Md.		NOV 14 1983		John J. Carroll					

\* Spine Spine Spine Spine

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be left within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

## MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						30460			
1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		REG. NO.			
				John		Philip		Chaires		11 2 83			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH		DAY		YEAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Male		White		7		7		30		11 2 83		2:00 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY) YRS.	
Maryland		U.S.A.		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY			
Chestertown		Kent and Queen Anne's Hospital		Truck Driver						Oil			
13a. STATE Md.		13c. CITY OR TOWN Rockhall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS South Main St. 21661							
14. FATHER'S NAME FIRST Albert		MIDDLE Benjamin		LAST Chaires		15. MOTHER'S MAIDEN NAME FIRST Katie		MIDDLE		LAST Dickerson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
Yes		Korean 215-26-4979		Mrs. Ella Chaires (Same as #13.)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Hepatic Failure -</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
5715 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF <u>Cirrhosis of liver</u> DUE TO, OR AS A CONSEQUENCE OF <u>Electrolyte imbalance</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <u>16/11/83</u>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. J. Day</u>		22c. ADDRESS		22d. DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 11/2/83		23c. NAME OF CEMETERY OR CREMATORIAL Balto., Md.		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 28 1983		25b. REGISTRAR'S SIGNATURE <u>James J. Curran</u>							
DHMH - 16 50M 4/82 (VRA 15, 4)													

## Introduction

[View modality](#)

## MARYLAND STATE DEPARTMENT OF HEALTH

30461

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 11, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Health Dept. and page 3 with the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 11, Page 5 may be retained for your files.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

Health plus to burial, cremation, or removal in any event within 72 hours of death.

## MEDICAL CERTIFICATION

1. DECEASED NAME (Type or Print)			First <b>HOWARD</b>	Middle <b>LINDEN</b>	Last <b>DONOVAN JR.</b>	2a. DATE KNOWN OF ESTI. DEATH MATED	Month <b>11</b>	Day <b>7</b>	Year <b>1983</b>	2b. HOUR <b>6 a.m.</b>	
3. SEX <b>MALE</b>	4. RACE <b>CAUC</b>	5. DATE OF BIRTH <b>8-31-15</b>	6. AGE (In years last birthday) <b>88 yrs.</b>	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	HOURS <b>0</b>	MIN <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>11</b> Day <b>7</b> Year <b>1983</b>			
7a. BIRTHPLACE (State or foreign country) <b>DELAWARE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>KENT</b>		2d. HOUR <b>8 a.m.</b>	
10. CITY OR TOWN OF DEATH <b>SASSAFRASS</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>AT HOME</b>			12a. USUAL OCCUPATION (Kind of work done during working life if retired.) <b>ACCOUNTANT</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>BOOKKEEPING</b> <b>21637</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>KENT</b>			13c. CITY OR TOWN <b>SASSAFRAS</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>RD BOX 35</b>	
14. FATHER'S NAME First <b>HOWARD LINDEN DONOVAN SR.</b>			15. MOTHER'S MAIDEN NAME First <b>ELIZABETH WOOLFORD</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>WW II</b>			17. INFORMANT <b>ANNE DONOVAN</b>			ADDRESS <b>WIFE SAME</b>		
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
4292											
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Robert W. Farr</i>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <b>Robert W. Farr, M.D.</b>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>11-9-83</b>			
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <b>Chestertown, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>11-10-83</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>ST. STEPHEN'S</b>			23d. LOCATION (City or Town) <b>EARLEVILLE, CECIL, MD</b>			(County) (State)	
24. FUNERAL DIRECTOR <b>EDW. FELLOWS &amp; SON CECILTON, MD 21913</b>		ADDRESS			25a. REC'D BY REGISTRAR <b>NOV 16 1983</b>			25b. REGISTRAR'S SIGNATURE <i>Joan J. Gandy</i>			

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												30462			
												REG. NO.			
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			Lula Elizabeth Gustafson						11 / 7 / 83			5:15AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
female		white		Nov. 12, 1918			64			YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland		USA					Kent			MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Chestertown		Kent and Queen Anne's Hospital		Housewife			RFD Morgnec			21620					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS RFD Morgnec					
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME											
		Christopher Conner		Elva Dixon											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			RFD 21620					
no		215 92 5918		Edward Gustafson			Chestertown, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pump failure												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 minutes			
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Macardia) Infarction												4 days			
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
							YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>Sept. 1975</u> , to <u>11-7-83</u> , that (I) (we) lost saw the deceased alive on <u>11-7-1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE		22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED								
				A.C. Dick, M.D.			11-7-83								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN COUNTY			STATE					
Burial		11/10/83		Chester Cemetery			Chestertown, Md.								
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
G. Willis Wells															

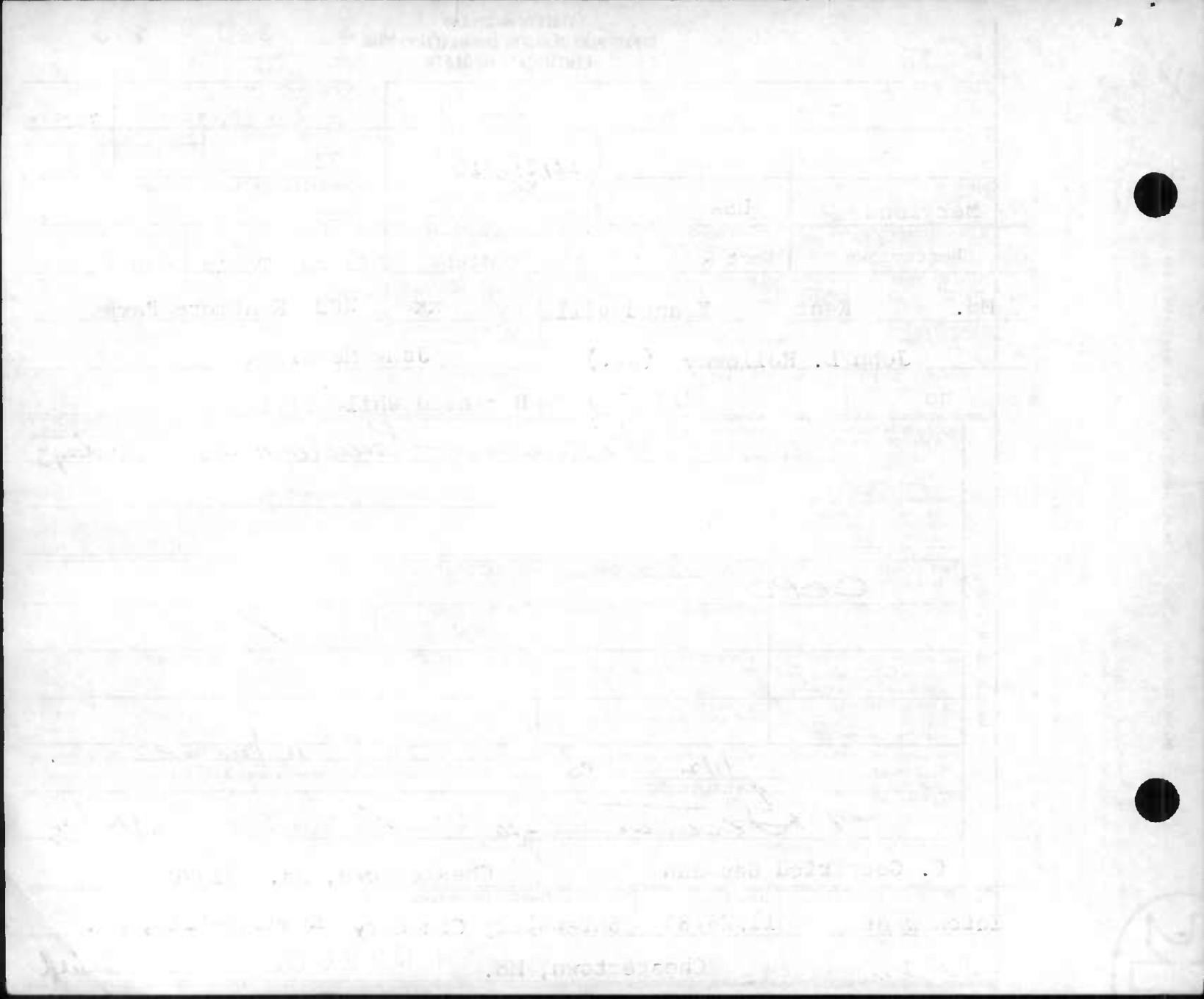


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83	30463		
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR					
John Laws Holloway					November 22, 1983					7:25 a.m.					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male		White		MONTH DAY YEAR		72		MONTHS DAYS		HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED XX		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Kent									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Chestertown		Kent & Queen Anne's Hospital										Distrb Tools		OWNER	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		MD.					
Md.		Kent		Kennedyville		XX		RFD Kentmore Park							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME										
John L. Holloway (Sr.)					Jane MacAllen										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
no		212 03 7579		Deceased while living											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4821 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												Pneumonia - Pseudomous 10 days			
DUE TO, OR AS A CONSEQUENCE OF (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. COPD															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/21/83 to 11/28/83, that (I) (we) last saw the deceased alive on 11/21/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>C. Gottfried Baumann</u>		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11/28/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Gottfried Baumann		22e. ADDRESS		Chestertown, Md. 21620											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Intombment		23b. DATE 11/26/83		23c. NAME OF CEMETERY OR CREMATORIAL Shrewsbury Cemetery		23d. LOCATION CITY OR TOWN Kennedyville, Md.		COUNTY		STATE					
24. FUNERAL DIRECTOR NAME Wallie Wells		ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR NOV 28 1983		25b. REGISTRAR'S SIGNATURE John J. Conroy									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

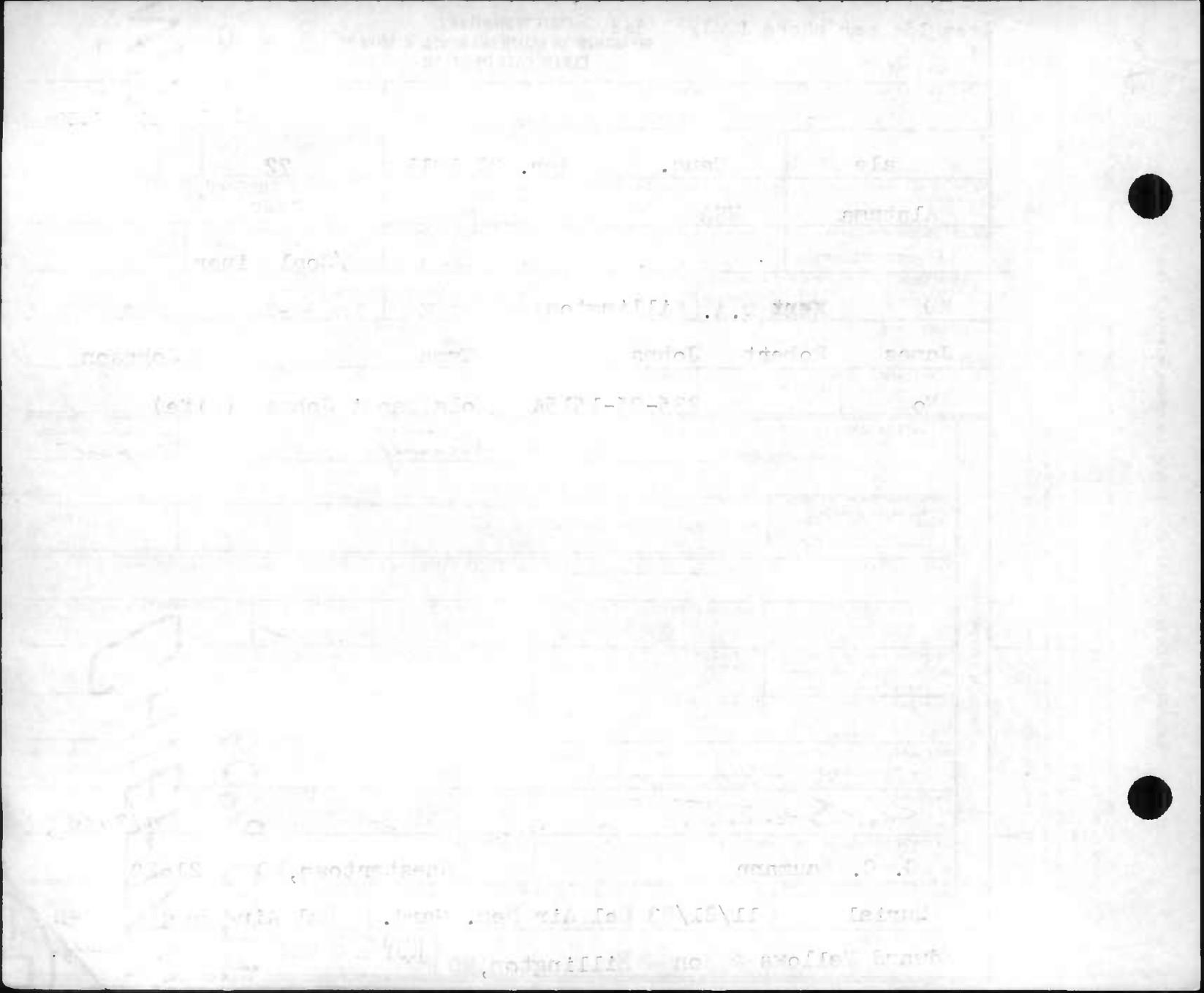
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 13e per phone 12/1/83 dad STATE OF MARYLAND  
FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
1 - STATE REGISTRAR CERTIFICATE OF DEATH

30464

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
			Tom	Watson	Johns		11	18	83	1:30 a.m.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
		Male		Cauc.		MONTH Day Year Apr. 22 1911		72	YRS.	IF UNDER 24 HRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Alabama		USA						Kent		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Chestertown		Kent & Queen Anne's Hospital				/Coal Miner				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		
MD		KENT		Millington				Box 40-B		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME					
		James	Robert	Johns	FIRST Emma		LAST Johnson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No		235-05-1515A		Zola Naomi Johns (wife)					1 year	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Causing</u> DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>5/25</u> , 19 <u>73</u> , to <u>11/17</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11/17</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>G. C. Baumann</u>		22c. DATE SIGNED <u>11/21/83</u>		DEGREE <u>C</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. C. Baumann		22e. ADDRESS Chestertown, MD 21620								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 11/21/83		23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Mem. Gard.		23d. LOCATION CITY OR TOWN Bel Air		COUNTY HARFORD		STATE MD
24. FUNERAL DIRECTOR NAME Edward Fellows & Son		ADDRESS Millington, MD		25a. DATE REC'D. BY REGISTRAR NOV 28 1983		25b. REGISTRAR'S SIGNATURE <u>J. M. Lohr</u>				

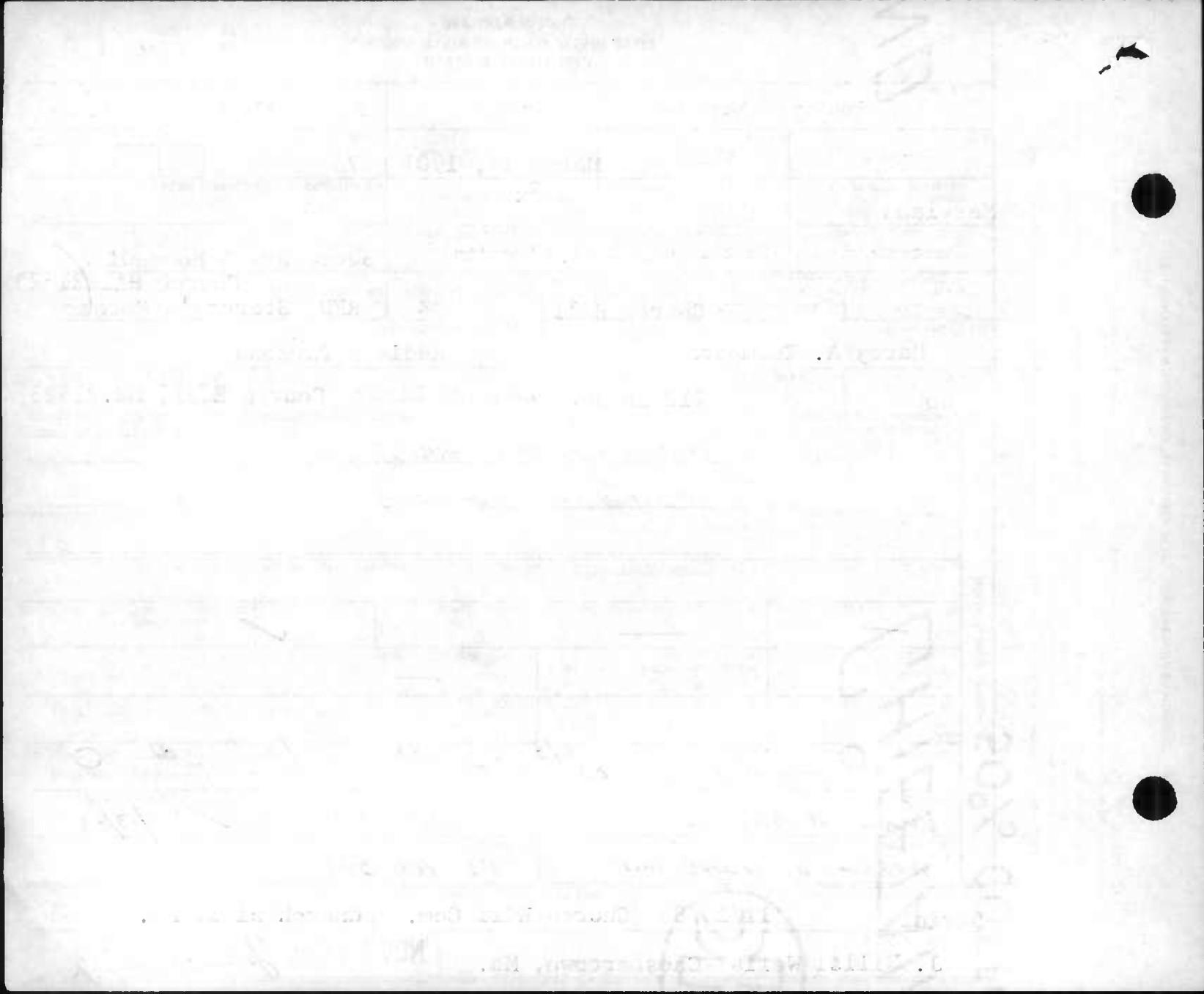


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										30-63				
1 - FOR STATE REGISTRAR		REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
		Eunice			Lorraine		Kirby			November 11, 1983				6:20p
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		March 19, 1907			76			MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Kent							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
Chestertown		Kent & Queen Anne's Hospital								Secretary & Housewife				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Maryland		Queen Anne		Church Hill						Church Hill 21623 RFD Starkey's Corner				
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME						
		Harry A.		Thompson				Addie			Parsons			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS							
no		212 10 9002		Lambert Kirby			Bx 61A Church Hill, Md. 21623							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> <u>4148</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial infarction</u> (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF														
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED			(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
		P.M. 19												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
		<u>on operation</u>												
22a. I certify that (I) this hospital attended the deceased from <u>11/11/83</u> to <u>11/11/83</u> , that (we) last saw the deceased alive on <u>11/11/83</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) we (did) (did not) view the body after death.														
22b. SIGNATURE <u>Virginia U. Collier</u>		22c. DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF		PHYSICIAN		DATE SIGNED		
				<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<u>11/13/83</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
VIRGINIA U. COLLIER MD		PO BOX 599												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
Burial		11/15/83		Church Hill Cem.			Church Hill, Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS												
J. Willis Wells		Chestertown, Md.												
25. DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE												
NOV 17 1983		John J. Conroy												

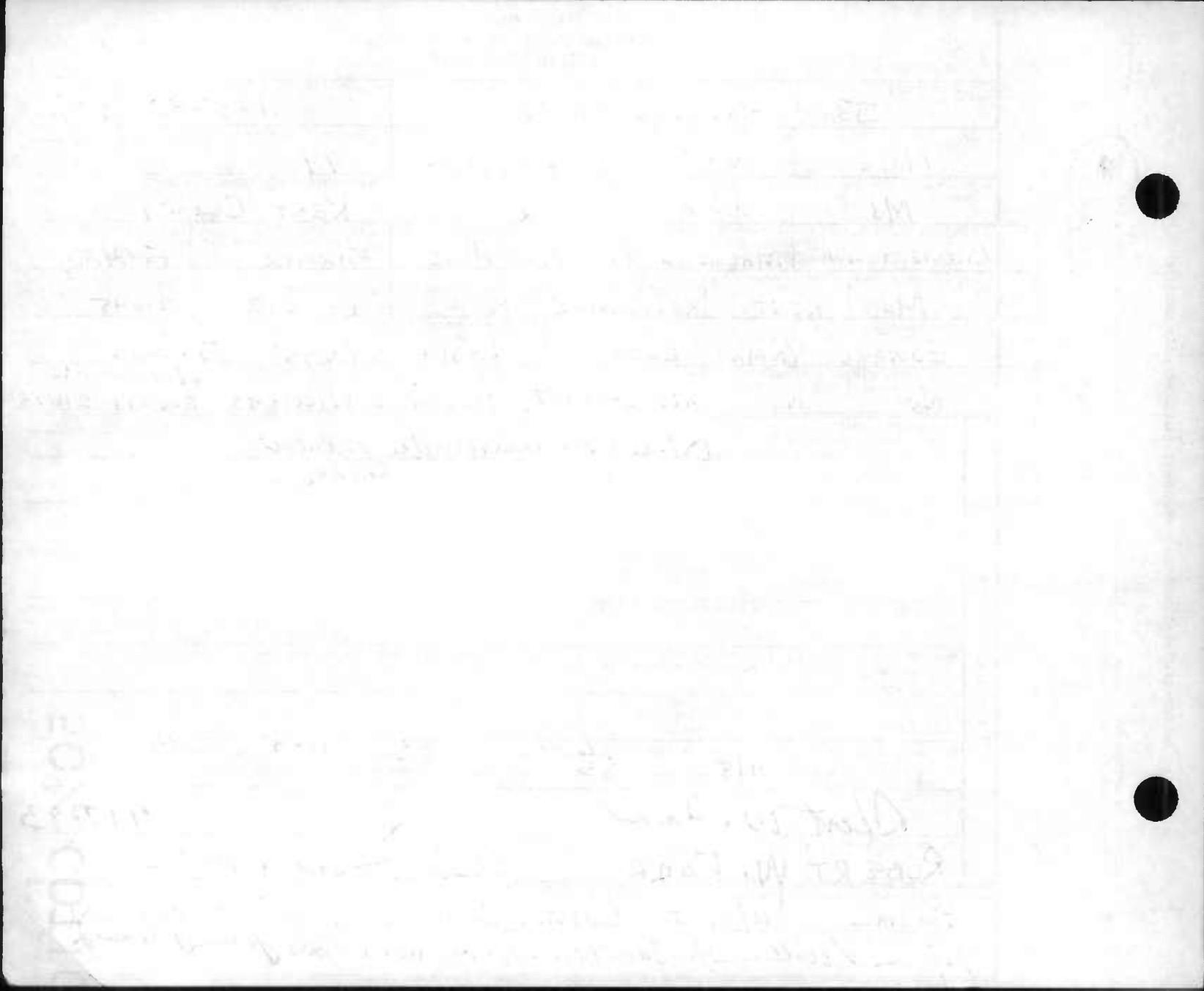


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										30466						
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR				
<b>JOHN RAYMOND LUSBY</b>						<b>11-5-83</b>						<b>6<sup>05</sup> P.M.</b>				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
<b>MALE</b>			<b>WHITE</b>			<b>4 - 10 - 1887</b>			<b>94</b>			YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
<b>Md.</b>			<b>U.S.A.</b>						<b>KENT COUNTY</b>							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
<b>CHESTERTOWN</b>			<b>MAGNOLIA HALL NSL. HOME</b>			<b>FARMER</b>			<b>FARMING</b>							
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
<b>Md.</b>			<b>KENT</b>		<b>KENNEDVILLE</b>		<b>RT 213</b>			<b>21645</b>						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME													
<b>EDWARD (NMN)</b>			<b>LYDIA (NMN)</b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<b>No</b>			<b>220-28-0450</b>			<b>HELEN L. WILLIAMS</b>			<b>WORTON, MD</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY:																
IMMEDIATE CAUSE (a)			<b>arterio sclerotic Cardio vascular disease</b>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)													
{																
DUE TO, OR AS A CONSEQUENCE OF																
(c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <b>6-1</b> , 19 <b>83</b> , to <b>11-5</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11-5</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
<b>Robert W. Far</b>												<b>11/17/83</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS													
<b>ROBERT W. FAR</b>			<b>Chestertown, Md.</b>													
23a. BURIAL, CREMATION, REMOVAL <small>(SPECIFY)</small>			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			STATES				
<b>BURIAL</b>			<b>11/8/83</b>			<b>CHESTER CEMETERY</b>			<b>CHESTERTOWN</b>			<b>KENT, MD.</b>				
24. FUNERAL DIRECTOR <small>(NAME)</small>												25a. DATE REC'D. BY REGISTRAR				
<b>Marie V. Williams</b>												<b>NOV 10 1983</b>				



**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

30-67

REG. NO.

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-100, SEPARATELY. PAGE 5, FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF EMBALMING, 701 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.	
Alwyn Ormsby							
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 64 yrs.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH DAY YEAR
male	white	4/18/1919				11/6/ 1983	2b. HOSPITAL NAME
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
New York State	USA		Kent				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
Chestertown	Kent & Queen Anne Hosp.	Carpenter					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md.	13b. COUNTY Queen Anne	13c. CITY OR TOWN Crumpton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS P.O. Bx # 252	21628			
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST		
Gordon	Ormsby		Flossie	Barton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT Maude Ormsby	ADDRESS Woron, Md.	P.O. Bx 252			
yes	WW 2 714 16 2912						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  4100 IMMEDIATE CAUSE (a) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MD	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE  TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER DATE SIGNED 11-7-83							
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS Chestertown, Md. 21620						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE 11/7/83	23c. NAME OF CEMETERY OR CREMATORIALy	23d. LOCATION CITY OR TOWN	23e. COUNTY	23f. STATE		
Cremation		Silverbrook Crematory	Wilmington, Del.				
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR NOV 14 1983					25b. REGISTRAR'S SIGNATURE 	
Willis Wells	Chestertown, Md.						

(28)

First Grade 1877-1880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 30-68
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
	Grace	NMN	Weller	November 27, 1983 7:44 P.M.
3. SEX <b>FEMALE</b>	4. RACE <b>CAUC.</b>	5. DATE OF BIRTH <b>XXXX 7-7-05</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Kent</b>	
10. CITY OR TOWN OF DEATH <b>Chestertown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Kent &amp; Queen Anne's Hosp. Inc.</b>			12a. USUAL OCCUPATION (TYPE OR PRINT) <b>HOMEMAKER</b>
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>QA.</b>	14. FATHER'S NAME <b>HOWARD</b>	MIDDLE <b>BOWDLE</b>	LAST <b>AMELIA</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>NO</b>	16b. SOCIAL SECURITY NO. <b>214-34-6133</b>	17. INFORMANT <b>GRACE Betty Greenwood</b>	ADDRESS <b>daughter same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <b>① Ph. Edema ② Bilateral lobar Pneumonia ③ Hypertension</b>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED <small>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></small>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>11/23</b> , 19 <b>83</b> , to <b>11/27</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11/27</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>KIN KUE WUN</b>	22c. DEGREE <b>MS</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <b>11/29/83</b>	
23a. BURIAL, CREMATION, REMOVAL <small>IF CEMETERY</small>	23b. DATE <b>12-1-83</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>SUDLERSVILLE CEM.</b>	23d. LOCATION CITY OR TOWN <b>SUDLERSVILLE QA MD</b>	23e. COUNTY STATE
24. FUNERAL DIRECTOR <b>EDW. FELLOWS &amp; SON MILLINGTON, MD</b>	25a. DATE REC'D. BY REGISTRAR <b>DEC 07 1983</b> B. REGISTRAR'S SIGNATURE <b>Janice Canfield</b>			

M



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 27 days after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 30469						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Eugene Williams									Williams			November 9, 1983				6:50P M		
3. SEX Male			4. RACE Black						5. DATE OF BIRTH Month Day Year Oct. 17 1900			6. AGE (IN YEARS LAST BIRTHDAY) 83			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE Carolina			7b. CITIZEN OF WHAT COUNTRY? U.S.A.						8. MARRIED NEVER MARRIED WIDOWED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH Kent			MD.			
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Md.			13b. COUNTY Kent			13c. CITY OR TOWN Worton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS RFD 21678						
14. FATHER'S NAME UNK									15. MOTHER'S MAIDEN NAME UNK									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 212-09-8975			17. INFORMANT Mrs. Lucille Raub			ADDRESS R. S. D. Worton, Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2030																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b)															
			DUE TO, OR AS A CONSEQUENCE OF (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART Ia Renal Failure																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-29 1969 to 11/9 1983, that (I) (we) last saw the deceased alive on 11/9 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <i>Gottfried C. Baumann</i>						DEGREE M.D.			ATTENDING PHYSICIAN GOTTFRIED C. BAUMANN			MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/14/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GOTTFRIED C. BAUMANN			22e. ADDRESS Chestertown, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BUR. & C			23b. DATE 11-12-1983			23c. NAME OF CEMETERY OR CREMATORIAL Mt Oliv. Cem.			23d. LOCATION CITY OR TOWN Worton			COUNTY Kent			STATE Md.			
24. FUNERAL DIRECTOR NAME <i>Benedict D. Chesapeake</i>			ADDRESS Chesapeake						25a. DATE REC'D. BY REGISTRAR NOV 21 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Conwell</i>						

1960-1962 Color David